

Chapter 2

General Instructions And Administrative Procedures

Introduction

The most important thing to remember--and to practice, in an emergency situation--is to remain calm and well-organized. The *Emergency Information Questionnaire* at the end of this chapter is designed to help the transport technician gather critical information in an organized fashion. Until detailed information about the patient's situation is available, it will be impossible to determine what course of action to take, and likewise impossible to begin *giving* appropriate information that will insure cooperation from hospital personnel and others involved in the patient's care.

It should be kept in mind that the response of hospitals, coroners, and other professionals who may have control of a patient during or after clinical death will depend largely on how they are dealt with. In most situations, healthcare or medicolegal professionals will be reasonably willing to cooperate, provided they are given a clear explanation of what the objectives of transport are, as well as a detailed understanding of their role in facilitating transport.

There no doubt will be some situations in which the individuals in charge of the patient are polarized, belligerent, and hostile. In such situations, it may well require every resource of patience, firmness, and legal pressure which can be mustered just to get access to the patient. In-depth treatment of psychological and behavioral strategies in dealing with such a confrontational situation are beyond the scope of this manual, and will be treated in detail elsewhere.

Most situations will be fairly straightforward, with the primary objectives of the transport technician being explanation of the purpose of transport and of cryonic suspension, and clear, concise, reassuring instruction of the professionals in charge of the patient.

Central Support

In most emergency situations, the transport technician in the field will not have been called in on a case until after Alcor Southern California (ASC) has been contacted and brought into the communications loop. This generally implies that ASC will have done a preliminary assessment of the situation. In such situations, basic information on the *Emergency Questionnaire* should be obtained from ASC and updated as needed. ASC will be the first line of organization and communication. The ASC phone number is (714) 736-1703. At this number, someone is either present or available via pager at all times.

Regardless of whether or not ASC has done preliminary groundlaying with hospital or other personnel, it is desirable to repeat these questions and the instructions in the *Emergency Instructions* at the end of this chapter when arriving on the scene. Basic needs

and emergency instructions will need to be repeated many times during the course of an emergency. Hospital and nursing home personnel generally change shifts every 8 hours: 3 times per day. As a consequence, new personnel will need to be briefed about the patient's situation and unique needs, and questions relating to both the specifics and the generalities of the procedure will need to be addressed repeatedly.

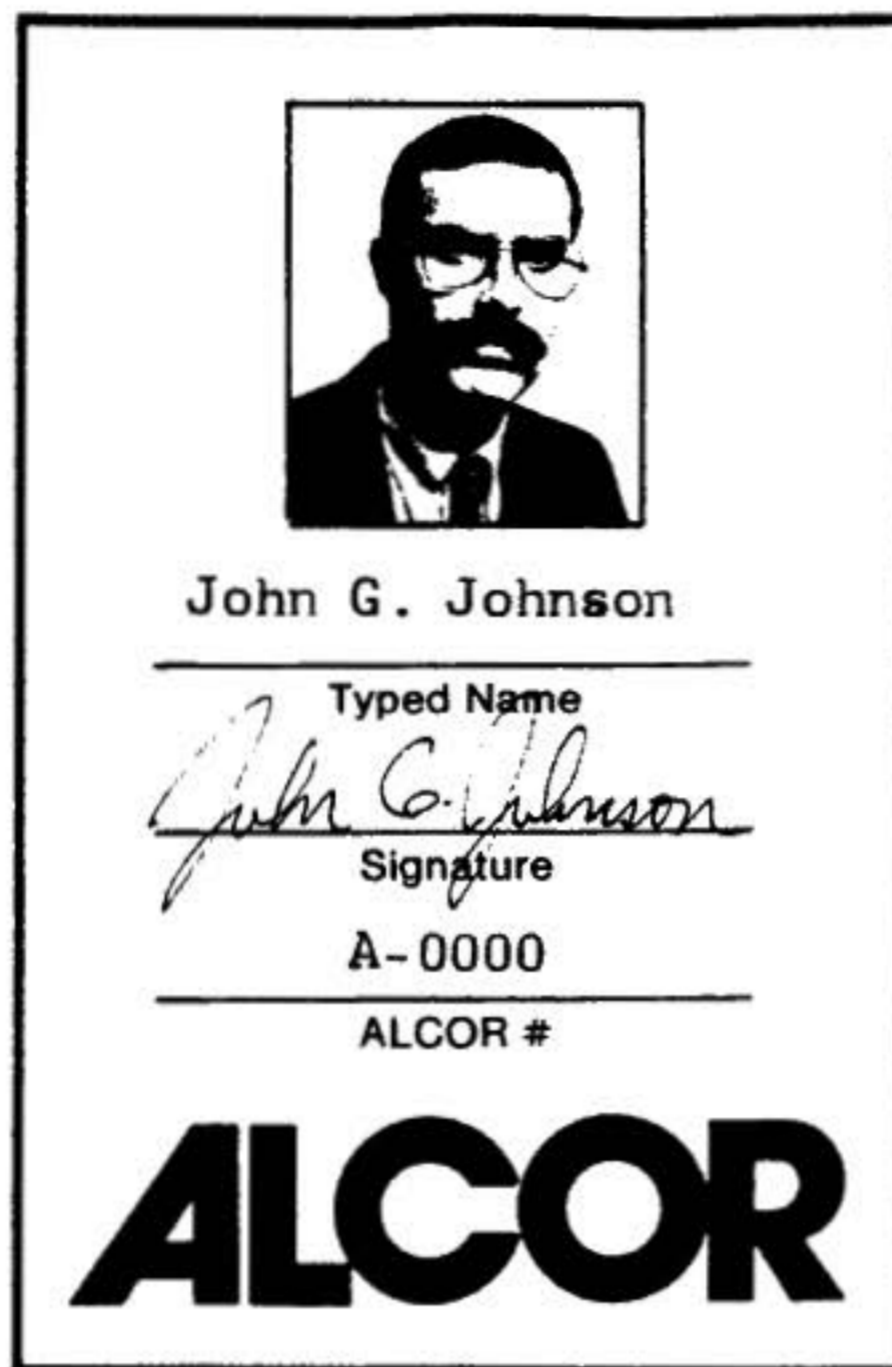


Figure 2-1: Alcor ID Badge.

Identification

All Alcor rescue personnel are issued a photo ID badge (above). The badge is worn to allow immediate identification of the person as a representative of Alcor, while facilitating communication by personalizing him/her. Hospital and other medical personnel will usually be wearing ID badges as well. When communicating with medical personnel, use their names. This puts communication on a personal level, which greatly improves the chances of cooperation. If legal leverage is needed, such as explanation of potential liability to criminal or civil litigation, addressing an individual by name is an effective means of stripping away his/her institutional protection. Also, in any situation of conflict, be sure to make the *individual's* actions the object of disagreement, never the institution's.

Asking For Cooperation

After gathering information about the patient's condition, prognosis, attending physicians, etc., *giving* information and obtaining cooperation are the primary

objectives. A concise explanation of the patient's arrangements for cryonic suspension is in order, as well as the provision of copies of appropriate legal documentation. This includes the *Informed Consent*, *Authorization of Anatomical Donation*, and a *will* or *codicil to a will* stating the patient's intent to be placed into cryonic suspension. Establishing legal authority to act in the patient's behalf is a crucial first step, providing reassurance that the transport technician is a competent professional.

Keep in mind that Alcor can FAX copies of these documents directly to the hospital if necessary, and that the originals can usually be delivered in 24 hours or less.

| URGENT INSTRUCTIONS | |
|--|---|
| <p>THE BEARER OF THIS CARD IS AN ANATOMICAL DONOR UNDER SECTION 7153.5(a) OF THE HEALTH AND SAFETY CODE OF CALIFORNIA AND HAS MADE ARRANGEMENTS FOR POST MORTEM CRYOGENIC PRESERVATION UNDER SECTION 7100 OF THE HEALTH AND SAFETY CODE OF CALIFORNIA. PLEASE FOLLOW THE INSTRUCTIONS BELOW:</p> | URGENT INSTRUCTIONS INSIDE |
| 1) IF UNCONSCIOUS, SERIOUSLY INJURED, OR CLINICALLY DEAD. IMMEDIATELY CALL (COLLECT) 714 736-1703 AND NOTIFY THE ALCOR FOUNDATION. STAY BY THE TELEPHONE TO RECEIVE INSTRUCTIONS. ALCOR PERSONNEL WILL BE PAGED. | |
| 2) IF CLINICALLY DEAD, START AND MAINTAIN CARDIOPULMONARY (HEART-LUNG) RESUSCITATION (CPR). | |
| 3) MAINTAIN ARTIFICIAL CIRCULATION AND VENTILATION AND ADMINISTER APPROPRIATE PARENTERALS TO MINIMIZE ACIDOSIS. | |
| 4) IF LEGAL DEATH HAS BEEN PRONOUNCED AND IT IS POSSIBLE TO DO SO, CONTINUE CPR AND PACK THE BODY IN ICE (ESPECIALLY HEAD, THROAT, AXILLA AND GROIN) OR PLACE ON A COOLING BLANKET AT 2 TO 4 DEGREES CENTIGRADE. | |
| 5) IF EXTENDED CPR IS NOT POSSIBLE OR INAPPROPRIATE (DONOR DEAD MORE THAN ONE HOUR) PACK THE BODY IN ICE. | |
| 6) DO NOT UNDER ANY CIRCUMSTANCES ALLOW THE BODY TO FREEZE OR BE EXPOSED TO SUBFREEZING TEMPERATURES (i.e., BELOW 0 DEGREES CENTIGRADE OR 32 DEGREES FAHRENHEIT). | |
| DO NOT AUTOPSY OR EMBALM. | |
| Call ALCOR (714) 736-1703 DONOR NUMBER _____ | |

Figure 2-2: Alcor Emergency Instructions/Anatomical Gift Card.

Concerns About Ethics Or Liability

Some hospitals or nursing homes will refuse to provide "active" cooperation of any kind after legal death has been pronounced due, to fear of liability. In such situations, they argue that they are not competent in cryonics procedures and cannot be involved for both legal and ethical reasons.

Offering a *hold-harmless* or other release from liability may be critical in securing cooperation. The *Letter To Hospital Personnel*, which follows this Chapter, provides such a legal release and "hold-harmless."

When a physician or hospital administrator is simply being belligerent or uncooperative without good reason (i.e., on the basis of personal beliefs or prejudices), the reverse tactic may work. If a physician or hospital official is concerned about the possibility of litigation should he *do* something, informing this person that if he *doesn't* do something he is *guaranteed* litigation--by Alcor--is a dangerous but occasionally useful tactic to employ. A fuller discussion of this strategy and its implications will be covered elsewhere.

Continuity Of Care

Once a transport technician has become involved in the stabilization and transport of a patient, it is the technician's responsibility to remain with that patient until care is handed off to other responsible Alcor personnel. The only exception to this rule would be a situation in which a technician was ordered to relinquish custody of the patient by a coroner or other law enforcement official authorized to issue such an order. In such a situation, a written receipt for the patient, as well as the reason for such an order and the identification (badge number, etc.) of the individual giving the order, should be obtained and carefully noted.

Legal Protection Of The Transport Technician

Under no circumstances should any Alcor personnel visit (or be in the same room with) the patient alone before legal death is pronounced. A hospital staff member or a relative of the patient must always be in attendance. This should be communicated to hospital personnel as soon as possible. For reasons of liability--both criminal and civil--it is inappropriate for any Alcor representative to have unsupervised access to the patient. This is so due to Alcor's potential "conflict of interest" under the law. Since Alcor could be accused of standing to gain financially from the patient's clinical death, there should be no possibility of accusations that there was unfavorable influence or direct action by Alcor personnel resulting in (or hastening) the patient's clinical death.

Record Keeping

An essential element of good care is adequate record keeping. Early in an emergency situation, it is *important* to reliably note down the names, phone numbers, and relationships of key people: relatives, physicians, nursing personnel, etc. Often, when transport begins, it will be impossible to make detailed notes, particularly if only one person is available to carry out stabilization. Nevertheless, certain key milestones must be noted during the course of suspension operations.

Examples of things which should be recorded as they occur or as soon as possible thereafter are:

- 1) Visits to the patient by the Transport Technician and observations regarding the patient's mental state and competence or lack thereof.
- 2) Significant conversations. What was said and by whom? When and where was it said (place, time, and date)? What was the attitude of all parties involved in the conversation? It is especially important to note any commitments that are made or given by either or both parties. The presence or absence of good notes can make a tremendous difference if legal action is initiated at some time in the future. Clearly, any conversations in which hospital administrators, physicians, or others express threats or make statements about noncooperation should be carefully noted.
- 3) Medical Information regarding the patient's condition. Who provided the information? Where and when did s/he provide it? If notes are made on the basis of observations from the chart, this should be clearly stated, and the date and time of the chart entries on which they are based should be recorded.

4) *Medications given must be charted.* Even if this means a delay in giving the medication, it *must* be charted. Such charting should include the drug, dosage, route administered (i.e., via nasogastric tube, central venous line, peripheral IV...). A checklist for this purpose is provided in the *Transport Data Collection Sheet*, which appears at the end of this chapter. *The working presumption in medicine and in cryonics is that if it was not charted, it was not given.* Charting on the check list also provides an opportunity to reaffirm that medications have been properly drawn up.

Other relevant information about the patient's legal death and transport should also be recorded on the *Transport Data Collection Sheet*.

Personal Preparation

Equipment and supplies for transport and stabilization should be kept readily accessible *indoors**, in a clean and dry area. It is necessary to maintain a packed overnight kit (ONK), which should contain as a minimum:

- 1) An attractive change of clothing: dress slacks and dress shirts which are subdued in color (gray, black, or navy blue wool slacks and a white or blue broadcloth or oxford cloth shirt) are preferred.
- 2) A white, full length lab coat.
- 3) Two sets of shoes and socks.
- 4) Appropriate hygienic supplies: razor, shaving cream, soap, shampoo, bath towel, deodorant, and other personal supplies which may be necessary for comfort and professional appearance.
- 5) Personal medical items: medications, contact lens supplies, etc. Especially important is a small supply of aspirin or other mild anti-inflammatory and analgesic for headaches or minor muscle aches and pains. Those who wear eyeglasses or contacts should consider storing their spare sets in their ONKs.
- 6) A warm- *and* a cold-weather jacket is essential. You may be expected to transport patients in winter or summer anywhere in the world.
- 7) It is suggested that high energy snack foods with a long shelf life be included in your ONK. Have enough to keep yourself going for several hours. When you land in the midst of an emergency, perhaps in the middle of the night in a strange city, there may be no time or opportunity for a warm meal--or a meal at all. Low blood sugar can seriously impair performance, and it may be many hours after you arrive before you have a break in the action long enough for a meal.
- 8) Maintain a copy of this manual in your ONK, and remember to bring your *Alcor Representative's Handbook* with you.
- 9) The ONK should be small enough to carry on an aircraft with you so that time is not lost waiting for luggage to be offloaded from the aircraft. This means it must fit under the seat or in the overhead compartment.

*Temperature should be between 60° and 90°F, with a relative humidity of no more than 70%.

The ONK should contain enough of the above supplies to allow personnel to remain on-site in comfort for at least 48 hours. Absence of such basic necessities as clean clothing not only impacts public perception of the credibility of the technician, but also can seriously impair working performance.

Date _____



Dear Sir or Madam,

I would like to inform you that _____, a patient in your facility, has made arrangements with our organization for cryonic suspension. We are aware that most institutions have little or no experience with this kind of procedure, so we would like to take this opportunity to provide you with some useful information about our protocols, and to ask for your non-interference in expediting the removal of the patient's "remains" from your facility in the event of his or her clinical and legal death.

At such a time as clinical and legal death is declared, we request the release of the entire body, *without embalming or autopsy*, to the Alcor Transport Team, which will be standing by. We would greatly appreciate your cooperation and support in:

1) Notifying us promptly if the patient's death appears imminent, or if there is a sudden change for the worse in the patient's condition, or if death suddenly occurs, so that the Transport Team can be deployed with Alcor stabilization equipment, and

2) Instituting Cardiopulmonary resuscitation immediately after legal death has been pronounced, with the objective of minimizing ischemic injury. It is important to point out that if the patient is clearly terminal (e.g., with advanced malignancy, multisystem organ failure, etc.) and has no-code status, CPR is intended to maintain perfusion and minimize ischemic injury--not to restore normal respiratory and cardiac function. *The objective of Alcor's Transport Protocol is the minimization of ischemia-associated post-mortem deterioration, not the immediate restoration of life.*

Transport personnel will be paged by radio, and will bring a vehicle equipped with a heart-lung resuscitator (Thumper) and/or a mobile extracorporeal perfusion unit (gurney mounted blood pump, membrane oxygenator, and heat exchanger) to your institution for transfer of the patient to our facilities. We understand the time and staffing constraints your institution faces, and we do not insist on extended periods of CPR in the face of practical limitations (i.e., no Thumper available).

Accompanying this letter, you will find a copy of a properly executed set of legal documents establishing Alcor's authority in this matter. Any receipts or paperwork you require from Alcor either will be presigned and in your possession, or executed within twenty-four hours of transfer of the patient, whichever your institution requests. With regard to this matter, we request that you discuss these details with our representatives at the earliest possible time, so that no confusion will exist in the event of the death of the patient.

In return for your cooperation in this matter, the Alcor life Extension Foundation releases you, your successors, assigns, or any agents or others acting for you, from any and all liability in the post-mortem handling and transfer of the patient's remains to Alcor or Alcor's agents or assigns. We appreciate your lack of familiarity with cryonic

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suspension and intend this release to be all-inclusive. For the patient's sake, we need your non-interference, and we understand that in this regard you expect to be held harmless and free of all liability from the consequences of any actions taken to assist us in this matter.

Thank you for your cooperation. If you have any questions, please don't hesitate to contact us.

Sincerely,

Carlos Mondragón
President

EMERGENCY INSTRUCTIONS FOR STABILIZATION OF ALCOR BIOSTASIS PATIENTS

Introduction

Biostasis is a low temperature preservation process applied to patients after they have exhausted the resources of contemporary medical care and have been pronounced legally dead. The process of placing a patient into biostasis involves prompt "post-mortem" cardiopulmonary support (to minimize ischemic damage), concomitant with induction of hypothermia by surface and/or blood cooling, treatment of the patient with agents to minimize freezing damage, and cooling to ultra low temperature for continued long-term care. The ultimate objective of biostasis is the restoration of life and health to the patient at some point in the future when biomedical technology has reached a degree of sophistication equal to reversal of the cause of death as well as the injury which results from the application of current, unperfected preservation techniques.

Stabilization Protocol

If the patient is pronounced dead (i.e., resuscitation efforts have failed or were deemed medically inappropriate), we request that you allow the Alcor Transport Technician to undertake the following steps:

1. **Cardiopulmonary resuscitation (CPR):** *Immediately* begin administration of 100% oxygen via face mask or (preferably) endotracheal tube or esophageal gastric tube airway (EGTA) using positive pressure ventilation. Begin sternal compression.

If a mechanical heart-lung resuscitator (such as the Thumper) is available, apply it.

Continue CPR during the administration of all medications listed below.

Do not defibrillate the patient.

2. Establish and maintain a patent intravenous line (preferably a subclavian or peripheral cut-down) for administration of all medications. Patency of the IV should be maintained by filling the catheter with heparinized saline (2,500 units of heparin per cc) or maintaining TKO flow of normal saline or other solution *which does not contain dextrose*.

3. Administer **potassium chloride** 1 mEq/kg, IV push to reduce cerebral metabolic demand *or* **sodium pentobarbital** 30 mg/kg IV push.

4. Administer **deferoxamine HCl (Desferal)** 2 g, IV push to scavenge free iron and reduce ischemia-induced free radical damage.

5. Administer **nimodipine** 10 *micrograms*/kg, IV push, followed by continuous IV infusion at a rate of 60 *micrograms*/kg/hour.

As an alternative to nimodipine, **diltiazem HCl** may be given in a dose of 300 *micrograms*/kg, IV push.

The purpose of both nimodipine and diltiazem is the prevention of cerebral vasospasm and protection against intracellular calcium loading and cerebral "no-reflow".

6. Administer **sodium citrate** 120 mg/kg, IV push to chelate serum calcium and reduce cerebral reperfusion injury.
7. Administer **Trolox** 80 mg/kg, IV push, followed by continuous infusion at a rate of 10 mg/kg/hour.
8. Administer **ascorbic acid (Cevalin)** 125 mg/kg by continuous IV infusion. (Note: the ascorbic acid may be added to the mannitol).
9. Administer **tromethamine (THAM)**, 250 mg/kg, IV (give 200 cc of 0.3 molar THAM rapidly, then set rate of infusion at 30 drops per minute) to combat acidosis.
10. Administer **heparin**, 420 IU/kg, IV push for anticoagulation.
11. Administer **chlorpromazine HCl (Thorazine)**, 3 mg/kg IV push to provide membrane stabilization and protection against cold ischemic injury.
12. Administer **methylprednisolone HCl (Solu-Medrol)**, 1 g by slow IV injection to provide membrane stabilization and protection against cold ischemic injury.
13. Administer **mannitol (Osmitrol)**, 2 g/kg, high-flow IV infusion to reduce ischemia-induced free radical injury and prevent cerebral edema.
14. Concurrently with the above, begin surface cooling by **packing the patient in crushed or small-cubed ice**. Particular attention should be given to packing the head, neck, axillary, and femoral areas in ice. In situations where the supply of ice is limited, concentrate on cooling the head and neck.
15. Administer **metubine iodide (Metubine)**, 0.07 mg/kg or **succinylcholine** 0.80 mg/kg, IV push to inhibit any possible shivering.
16. Administer **gentamicin sulfate (Garamycin)** 1 mg/kg IV push and **Bactrim: trimethoprim** 160 mg and **sulfamethoxazole** 800 mg by slow IV infusion to inhibit microbial overgrowth.

Alternatively, **erythromycin (Erythrocin)**, 1 g adults or 500 mg for children under 12, (or if unavailable, **Keflex** 1 g), IV push may be used.
17. Immediately prior to the administration of **dextran-40**, administer 1.5 g of **dextran-1 (Promit)** IV push to prevent possible anaphylactic reaction to dextran-40. Do not delay the start of the dextran-40 infusion longer than 15 minutes after the Promit has been given.
18. Administer **dextran-40 (Rheomacrodex)** *in normal saline only*, 250-500 cc via high flow IV infusion to minimize capillary sludging and to support blood pressure (in volume depleted patients). *Do not use Rheomacrodex solutions containing dextrose.*
19. **Continue CPR for at least 10 minutes** after the injection of the last medication.
20. It is highly desirable to **continue cardiopulmonary support until a pharyngeal temperature of 15°C or a rectal temperature of 25°C has been reached.**
21. If a nasogastric tube is in position, it should be used to administer 250 cc of **Maalox, Riopan, or Titalac**, in order to neutralize gastric hydrochloric acid and eliminate the risk of erosion of the gastric mucosa and hemorrhage during subsequent cryoprotective perfusion.

22. The eyelids should be closed with tape to prevent corneal dehydration.
23. Clamp but do not remove any drainage tubes, catheters, or IV lines in the patient.
24. Completely pack the patient in water ice for transport to our facilities.
25. It is of critical importance that the patient not be subjected to freezing temperatures (i.e., those below 0°C (32°F)). This includes, but is not limited to, storage in a hospital morgue "cooler" at a temperature below 4°C (34°F), temporary storage in an unheated ambulance, hearse, or aircraft during transport when the ambient temperature is below freezing, or the use of refrigerants such as dry ice or water ice/salt mixtures for cooling or transport. If there is any question about the accuracy or reliability of mechanical refrigeration equipment, it should be checked frequently on a manual basis with an accurate thermometer.
26. If you need further information call the emergency number listed below and ask to be connected with the Emergency Rescue Technician on call.

EMERGENCY PHONE #: (714) 736-1703

Thank you for your cooperation.

An abbreviated protocol for use in situations where cooperation is minimal or where the interval between the start of cardiac arrest and the discovery of the patient is greater than 60 minutes is as follows.

ABBREVIATED EMERGENCY INSTRUCTIONS FOR STABILIZATION OF ALCOR BIOSTASIS PATIENTS

Introduction

Biostasis is a low temperature preservation process applied to patients after they have exhausted the resources of contemporary medical care and have been pronounced legally dead. The process of placing a patient into biostasis involves prompt "post-mortem" cardiopulmonary support (to minimize ischemic damage) concomitant with induction of hypothermia by surface and/or blood cooling, treatment of the patient with agents to minimize freezing damage, and cooling to ultra low temperature for continued long term care. The ultimate objective of biostasis is the restoration of life and health to the patient at some point in the future when biomedical technology has reached a degree of sophistication equal to reversal of the cause of death as well as the injury which results from the application of current, unperfected preservation techniques.

Stabilization Protocol

If the patient has been pronounced dead and has experienced a period of more than 60 minutes of normothermic cardiac arrest (in the absence of any cardiopulmonary support) and there is no rigor mortis present (if rigor is present do not administer any IV medications and proceed to #9 below), we request that you undertake the following steps:

1. Carry out sternal compressions **without ventilating the patient** at a rate of 60 per minute **during** and for 5 minutes **after** the administration of the following medications:
2. **Heparin**, 800 IU/kg IV push for anticoagulation.
3. **Streptokinase (Streptase)** 30,000 IU/kg IV push to a maximum dose of 2,250,000 IU to reverse/inhibit ischemia related clotting.
4. **Deferoxamine (Desferal)** 2 g, IV push to scavenge free iron and minimize ischemia-induced free radical damage.
5. **Verapamil (Isoptin, Calan)** 0.30 mg/kg, IV push to reduce ischemia-induced intracellular calcium loading.
6. **Chlorpromazine HCl (Thorazine)**, 3 mg/kg IV push to provide membrane stabilization and protection against cold ischemic injury.
7. **Methylprednisolone HCl (Solu-Medrol)**, 1 g by slow IV injection to provide membrane stabilization and protection against cold ischemic injury.
8. **Erythromycin (Erythrocin)**, 1 g, (or if unavailable Keflex 1 g), IV push to inhibit microbial overgrowth.
9. Cool the patient as quickly as possible by completely packing the body in bags of crushed or small cubed water ice. In situations where the supply of ice is limited, concentrate on the head.

10. If a nasogastric tube is in position, it should be used to administer 250 cc of Maalox, Riopan, or Titralac, in order to neutralize gastric hydrochloric acid and eliminate the risk of erosion of the gastric mucosa and hemorrhaging during subsequent cryoprotective perfusion.
11. The eyelids should be closed with tape to prevent corneal dehydration.
12. Clamp but do not remove any drainage tubes, catheters, or IV lines in the patient.
13. Completely pack the patient in water ice for transport to our facilities.
14. It is of critical importance that the patient not be subjected to freezing temperatures (i.e., those below 0°C (32°F)). This includes, but is not limited to, storage in a hospital morgue "cooler" at a temperature below 4°C (34°F), temporary storage in an unheated ambulance, hearse, or aircraft during transport when the ambient temperature is below freezing, or the use of refrigerants such as dry ice or water ice/salt mixtures for cooling or transport. If there is any question about the accuracy or reliability of mechanical refrigeration equipment, it should be checked frequently on a manual basis with an accurate thermometer.
15. If you need further information, call the emergency number listed below and ask to be connected with the Emergency Rescue Technician on call.

EMERGENCY PHONE #: (714) 736-1703

Thank you for your cooperation.

Transport Data Collection Sheet

Date _____

Patient Name _____

Alcor # _____ Age _____ Weight _____ (kg) Temp* _____ (°C)

Time of Cardiac Arrest _____

Start of CPR - _____

Ischemic Time = _____

Start of External Cooling _____

*Rectal temperature at time of clinical death.

Medications Administered

| Drug | Dose | Amount | Package | Volume | Time |
|---|---------------------------|--------|---------|--------|------|
| Potassium chloride | 1 mEq/kg | | | | |
| OR | | | | | |
| Sodium Pentobarbital | 30 mg/kg | | | | |
| Deferoxamine HCl (Desferal) (Administer as IV push.) | | 2 gm | | | |
| Nimodipine (Administered as IV push.) | 10 <i>micrograms</i> /kg | | | | |
| Followed by 60 <i>micrograms</i> /kg/hr IV infusion. | | | | | |
| OR | | | | | |
| Diltiazem HCl | 300 <i>micrograms</i> /kg | | | | |
| Sodium Citrate | 120 mg/kg | | | | |
| Trolox | 80 mg/kg | | | | |
| Followed by 15 mg/kg/hr IV infusion. | | | | | |
| Ascorbic Acid (administer as IV infusion) | 125 mg/kg | | | | |
| THAM (Tromethamine) | 250 mg/kg | | | | |
| Heparin | 420 IU/kg | | | | |
| Chlorpromazine HCl | 3 mg/kg | | | | |

| Drug | Dose | Amount | Package | Volume | Time |
|---|--|----------------------------|-------------------------|--------|------|
| Methylprednisolone HCl | 1 g | 1 g | 1 g | | |
| Mannitol | 2 g/kg | | | | |
| Metubine Iodide | 0.07 mg/kg | | | | |
| OR | | | | | |
| Anectine | 0.8 mg/kg | | | | |
| Bactrim | (160 mg Trimethoprim and 800 mg Sulfamethoxazole) | | 80 mg/5cc 400 mg/5cc | 10 ml | |
| Gentamicin Sulfate (Garamycin) | 1 mg/kg | | | | |
| OR | | | | | |
| Erythromycin (Erythrocin) | | 1 gm (500 mg for children) | | | |
| Phenylephrine HCl (Neo-Synephrine HCl) | 0.3 mg/kg | | | | |
| (Dilute concentrate to 1 ml Neo-Synephrine in 9 ml normal saline.) | | | | | |
| OR | | | | | |
| Dopamine (Intropin) | 50 µg/kg/minute | | | | |
| (Dilute 400 mg in 500 ml normal saline, and set drip as calculated) | | | | | |
| Maalox, Riopan, or Titalac | | 250 cc | | | |
| Dextran-1 (Promit) | | 1.5 gm | | | |
| (Administer as IV push immediately before administration of Dextran-40) | | | | | |
| Dextran-40 (Rheomacrodex) | | 250 - 500 cc | | | |
| (Administer 250 cc slow infusion (prn to maximum of 500 cc)) | | | | | |

ALCOR EMERGENCY INFORMATION QUESTIONNAIRE

Introduction

Please make every effort to complete this form, being sure to ask all applicable and appropriate questions. Explain to the caller that we need this information to facilitate transport of the patient and to provide good care. It is particularly important to try to update the member's medical history information as much as possible, with particular emphasis on the most recent medical history.

Basic Information

1) What is the date and time of this call?

2) What is the name of the member in distress?

3) What is the member's Alcor Number?

4) Where is the member located? If it is a hospital or nursing home, what is the member's Floor #, and Room number?

5) What are the names of the attending physician and charge nurse?

6) Are there any plans to relocate the member, and if so, to where?

7) What is the full name of the calling party?

8) Where is s/he calling from?

9) Phone numbers where s/he can be reached?

10) What is the caller's relationship to the member?

11) Are there relatives of the member present, and if so what is the situation?

Medical Information

1) What is the member's current medical condition and prognosis?

2) Weight _____ Temperature _____

3) Any thoracic or abdominal surgery?

4) Recently diagnosed atherosclerotic disease or surgery (e.g., angioplasty, etc)?

5) Contagious or infectious disease (AIDS, hepatitis, tuberculosis...)?

7) Is the member conscious? _____

8) Current medications?

9) Has any possibility of autopsy or a coroner's or medical examiner's involvement been mentioned?

If The Patient Is Clinically Dead

1) When did cardiac arrest occur?

2) What was the "cause(s) of death"?

3) What was the patient's last temperature before the start of the ischemic coma?

4) Where is the patient now?

5) If the patient is under refrigeration, at what temperature is s/he being kept and how long after the start of the ischemic coma was cooling begun?

6) Has the patient been embalmed? _____

7) Autopsied? _____

Comments and Notes
